

2090.2 Choice of Health Professional.--The contract must allow each enrolled recipient to choose his or her health professional in the HMO to the extent possible and appropriate. The Medicaid recipient is allowed to select his or her primary care physician from among those whose practices are open to new Medicaid enrollees. It also means that the Medicaid recipient who has received prior authorization from the HMO for referral to a specialist or inpatient care, in consultation with the HMO and primary care physician, may choose among the specialists and hospitals available. (See 42 CFR 434.29.)

2090.3 Open Enrollment Period.--The contract must specify any procedures for enrollment or reenrollment, and must provide for an open enrollment period during which the HMO accepts Medicaid recipients who are eligible to be covered under the contract:

- o In the order in which they apply;
- o Without restriction, unless authorized by the Regional Administrator; and
- o Up to the limits set under the contract.

You and the HMO may identify in the contract the maximum number of Medicaid enrollees that an HMO accepts in the contract period.

The HMO must accept reenrollments on the same basis as enrollments during the open enrollment period. Reenrollment refers to Medicaid applicants for enrollment who are not now, but previously were, enrolled in the HMO to which they are applying. Such applicants are treated the same as first-time applicants and must be accepted in the order in which they apply, up to the limits established under the contract.

The regulations provide that eligible individuals must be accepted without restriction, unless authorized by the Regional Administrator. Therefore, the reenrollment rule also applies to applicants whose previous enrollment was terminated for cause. RO approval must be obtained before an individual is precluded from enrolling on the grounds that he or she was previously disenrolled for cause. (See 42 CFR 434.25.)

2090.4 No Enrollment Discrimination Based on Adverse Health Status.--The contract must provide that the HMO's procedures to enroll, reenroll, or disenroll Medicaid recipients do not discriminate among the individuals on the basis of their adverse health status or higher requirements for health care services.

Any HMO which acts to discriminate among individuals on the basis of their adverse health status or higher requirements for health care services (including expulsion or refusal to reenroll an individual) or which engages in any practice that has the effect of denying or discouraging enrollment by eligible individuals whose medical condition or history indicates a need for substantial future medical services, is subject to a civil money penalty. (See §2092.4.)

2090.5 Automatic Reenrollment.--Under §1903(m)(2)(H) of the Act, you may provide in your State Plan for the automatic reenrollment in an HMO of a Medicaid recipient who becomes disenrolled from that HMO solely by virtue of becoming temporarily (for two months or less) ineligible for Medicaid. The advantage of automatic reenrollment is that it reduces administrative costs to the managed health care plan for repeat marketing.

Advise recipients of the automatic reenrollment at the same time they are notified of their renewed eligibility for Medicaid and advise them (again) of their right to disenroll from the HMO. The notice must be easy to understand and must give the name, address, and phone number of a person to contact if recipients decide to disenroll from the HMO.

2090.6 Disenrollment Procedures of HMO.--With the exceptions identified in §§2090.9 through 2090.12, the contract must permit recipients who have enrolled in the HMO to disenroll voluntarily with no restrictions, effective at the beginning of the first month following the first full month after disenrollment is requested. The recipient need not give any reason or establish good cause for wanting to disenroll.

2090.7 Disenrollment Without Cause With No Restrictions.--Except in States which have exercised their option to allow certain types of HMOs and CMPs to restrict disenrollment for up to six months (see §2090.9), the contract must specify that the HMO enrollee may disenroll voluntarily and freely at any time. The disenrollment must be effective at the beginning of the first month following a full month after the individual requests the termination. Thus, if the recipient files a disenrollment form on April 30, the disenrollment must be effective on June 1 unless the recipient requests a later disenrollment date. The contract must provide that, at the time of enrollment, all individuals are notified of their right to disenroll without cause.

Ensure that disenrollment information is included in the marketing brochures and member handbooks. The disenrollment forms must be easy to obtain and must be available from you or the HMO through the mail if requested over the telephone. Ensure that recipients do not experience unreasonable barriers when they wish to disenroll.

If disenrollment forms are processed by the HMO and forwarded to you, ensure that you receive the disenrollment forms in time to generate FFS cards. You may want to require in the contract that the HMO give the recipient a copy of the disenrollment form indicating the date on which the recipient submitted the form and the effective date of disenrollment. This allows you to monitor the timeliness of the HMO's forwarding of disenrollment forms.

2090.8 Disenrollment Without Cause With No Restrictions in Mandatory Enrollment Program.--Under a §1915(b) freedom of choice waiver, a recipient may be mandatorily assigned to an HMO. In such cases, the recipients must be able to exercise their right to disenroll voluntarily and freely. Since there may be no FFS option in an area with mandatory enrollment in managed care, all mandatory enrollment capitation programs must offer at least one alternative source of medical care. The recipient may then disenroll from one and be mandatorily assigned to the other. This satisfies the voluntary disenrollment requirement.

2090.9 Disenrollment Without Cause With Restriction for Up to Six Months.--Under §1903(m)(2)(F) of the Act, you may provide in your State Plan for a restriction on the right of enrollees of certain entities to disenroll without cause. Under this restriction, an enrollee's right under §1903(m)(2)(A)(vi) of the Act to disenroll without cause can be limited to the first month of a defined enrollment period which may not exceed six months. This restriction is sometimes referred to as "lock-in" since the recipient is locked-in to receiving services from the HMO for a certain time period. This option does not apply under any circumstance to the recipient's right to disenroll for good cause.

If your State Plan provided for a restriction on disenrollment under this section, disenrollment is restricted under your contracts with the following entities:

- o Federally qualified HMOs or CMPs with a current Medicare contract with HCFA (see §2086.3) and which meet the enrollment composition requirement in §2086.8;
- o An HMO that meets the criteria in §1903(m)(2)(E) of the Act (see §2086.12);
- o Certain health centers with Federal funding described in §2086.7; and
- o The New Jersey Garden State Health Plan (see §2086.15), in which at least 25 percent of the members are individuals who (1) are not insured under Medicare Part B or Medicaid eligible and (2) in the case of government subsidized individuals, the enrollees had the opportunity to elect other coverage. (See §1903(m)(2)(F)(ii) of the Act.)

If your State Plan does not provide for restriction on enrollment under this section, the above entities may not restrict enrollment. The terms for restricted disenrollment are to be specified in an HMO's contract.

The recipient is allowed to disenroll without restriction during the first month of each enrollment period but may not disenroll without cause during the remaining five months of the enrollment period. During these remaining months, the recipient may disenroll only for good cause.

To restrict voluntary disenrollment, you must complete a State Plan preprint. On this form, you opt to restrict or to not restrict voluntary disenrollment. If you choose to restrict, it must also indicate the number of months of restriction (not to exceed five).

You are allowed some flexibility in modification of the State Plan preprint, such as designating specific HMOs to which the restriction of voluntary disenrollment applies.

If you choose to restrict the period in which the recipient may disenroll voluntarily, then you must provide notification at least twice per year to individuals of their right to terminate enrollment and of the restriction which you have placed on their exercising of this right.

States that choose to restrict disenrollment must require HMOs to notify Medicaid enrollees of their disenrollment rights prior to enrollment, at least 30 days before the start of a new period of enrollment, and at least twice a year.

2090.10 Voluntary Disenrollment With Indefinite Restriction in Certain HIOs.-A legislative amendment exempted from the requirement any HIO which became operational after January 1, 1986 but which operates under a §1915(b) waiver granted prior to January 1, 1986. This exemption applies during the period that the §1915(b) waiver is effective.

Despite exemption from the voluntary disenrollment requirement (and from the enrollment composition requirement), these HIOs must meet the other Federal Medicaid HMO requirements, and the RO must give prior approval to their Medicaid contracts.

2090.11 Recipient's Right to Disenroll for Good Cause From HMO With Restricted Disenrollment. -In an HMO where there is restricted disenrollment pursuant to §2090.9 and the recipient may not disenroll without cause, the recipient may disenroll for good cause at any time.

You must have a mechanism in place that ensures that you are aware of all requests for disenrollment due to good cause. Examples of reasons may include poor quality care, lack of access to specialty services covered under your State Plan or other reasons that you may establish. The HMO must be required to provide you with whatever information you may require to make a decision.

You may require recipients seeking to disenroll for good cause to use an organization's grievance process prior to deciding the case. It may be in the best interest of a State administered program that you have the authority to decide whether to require the use of the HMO's grievance procedure as part of a disenrollment for cause. You may prefer that HMOs use the less formal procedure as the initial (and perhaps only) step necessary to resolve a disenrollment for cause request. However, since it is required that you be informed of all disenrollment for good cause requests, you are able to begin your own processes in time to complete your work.

Termination of an enrollment for good cause must be effective no later than the first day of the second month after the month in which the recipient requested termination. Because you are informed from the start of the reason why disenrollment is sought, you are in a position to act swiftly to protect the needs of an enrollee whose health and well-being appear to be at risk.

An enrollee has the right under 42 CFR 431.220(a)(2) to appeal a decision by a State agency to uphold an HMO denial of a request to disenroll for good cause. The procedures in 42 CFR Part 431, Subpart E, apply to such appeals. As noted in §2090.9, you must inform potential enrollees of their disenrollment rights prior to enrollment, at least 30 days before the start of a new enrollment period, and at least twice a year.

2090.12 HMO's Right to Force Disenrollment. -In certain circumstances, Medicaid HMOs may force the Medicaid recipient to disenroll against his or her will.

The contract must specify the reasons for which the HMO may terminate a recipient's enrollment. The contract must also specify that the HMO may not terminate the enrollment because of an adverse change in the recipient's health. Finally, the contract must specify the methods by which the HMO assures you that terminations are consistent with the reasons permitted under the contract and are not due to an adverse change in the recipient's health. (See 42 CFR 434.27(a).)

Possible reasons for forced disenrollment may include disruptive behavior (not caused by a medical condition) at the HMO's facilities; fraudulent loaning of the HMO membership card to another person; or steadfast refusal to comply with managed care, such as repeated emergency room use combined with refusal to allow the HMO to treat the underlying medical condition.

2090.13 Guarantee of Eligibility. -Under §1902(e)(2) of the Act, you may provide in your State Plan for a minimum enrollment period, during which a Medicaid recipient enrolled in certain eligible entities retains eligibility for the Medicaid services the entity provides even if the enrollee otherwise loses Medicaid eligibility. This enrollment period may not exceed a maximum of six months following the date on which the recipient's enrollment in the eligible entity becomes effective.

The entities eligible for a minimum enrollment period (if you choose to provide for one in your State Plan) are:

- o Federally qualified HMOs (see §2086.3);
- o CMPs with a current Medicare contract with HCFA (see §2086.3);
- o An entity that contracted to provide non-inpatient Medicaid services prior to 1970 (see §1903(m)(2)(B)(iii) of the Act);
- o An HMO that meets the criteria in §1903(m)(2)(E) of the Act (see §2086.12);
- o Entities described in §1903(m)(2)(G) of the Act (see §2086.7); and
- o The New Jersey Garden State Health Plan (see §2086.15).

If a recipient loses Medicaid eligibility during a minimum enrollment period, he/she is entitled to coverage (through the end of the enrollment period) only for services furnished or arranged by the entity with which he/she is enrolled. This does not apply to family planning services when a recipient loses Medicaid eligibility during the minimum enrollment period.

In addition to making a decision whether to elect the guaranteed eligibility option, you are required to make a decision as to when a given enrollment period becomes effective for purposes of the six month time limit. (See §1902(e)(2)(B) of the Act.) You have three options for the effective date. You may elect to make the effective date of a current enrollment the earliest date on which a recipient was both Medicaid eligible and enrolled in the entity entitled to a minimum eligibility period. Under this option, if a recipient (1) becomes ineligible for Medicaid during a six month enrollment period, (2) continues to receive coverage of services by remaining enrolled in an entity entitled to guaranteed eligibility, and (3) becomes eligible for Medicaid again while still receiving services under the guaranteed eligibility option, a new enrollment period of up to six months begins on the date the recipient's Medicaid eligibility became effective.

Under the second effective date option, you may make the effective date of a six month enrollment period the date on which the enrollee first enrolled in the entity as a Medicaid recipient. Under this option, the guaranteed enrollment period ends six months after a recipient first enrolls as a Medicaid recipient, even if the recipient loses and regains Medicaid eligibility during this six month period. Finally, under the third option, enrollment is effective on the first date the recipient enrolled in the entity entitled to a guaranteed enrollment period, without regard to whether he or she enrolled as a Medicaid recipient.

Under any of the options, a new enrollment period begins any time a recipient enrolls with an eligible entity after a period when he or she was not enrolled (e.g., when he or she was enrolled in another HMO or was receiving FFS Medicaid coverage).

2091. QUALITY ASSURANCE

2091.1 Medical Services Provisions.-- The contract must specify in detail:

- o The amount, duration and scope of medical services to be provided, either directly or through arrangements;

- o The period for which the services are provided, if different from the contract period; and
- o Any financial or other limits on amounts of services to be provided.

If a contract is to exclude some benefits that are provided in the State Plan, these exclusions must be clearly defined and the procedures by which recipients are to obtain these services must be described. (See 42 CFR 434.6(a)(4).)

2091.2 Quality Assurance Evaluation Provisions.--The contract must contain provision(s) specifying that you and DHHS may evaluate, through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract. This contract provision must require the participation by the HMO in the required annual independent external review of the quality of services furnished under all HMO contracts with you as required in compliance with §1902(a)(30)(C) of the Act. (See 42 CFR 434.6(a)(5).)

2091.3 Record System Provisions.--The contract must require that the HMO maintain an appropriate record system for services to enrolled recipients. A medical/health record must be maintained for each enrollee. There must be a system and procedure for recording essential clinical information (including linking information on inpatient care to outpatient records); for making this information accessible in an expeditious manner to appropriate health professionals; and for facilitating continuity of health care. The central HMO office must keep at least a summary record for this purpose to assure access to critical data in cases of emergency. (See 42 CFR 434.6(a)(7) and 434.34(b) and (c).)

2091.4 Recipient Enrollee Information Safeguards.--You are required to include or incorporate in your contracts with HMOs the safeguards against inappropriate disclosures of information on recipients that you have established pursuant to 42 CFR Part 431, Subpart F and §2080.15. (See 42 CFR 434.6(a)(8).) HMOs are responsible for complying with the information safeguards established in the State with which they have a contract.

Advise HMOs to consult with you for more information on what an HMO's obligations are under a given State's safeguards. With the exception of the requirements in 42 CFR 431.301-303, HMOs must comply with all the requirements in 42 CFR Part 431, Subpart F.

2091.5 Emergency Services.--42 CFR 434.30 stipulates that, if the contract covers emergency services, it must:

A. **Assure Availability.**--The contract must provide that all covered emergency services are available 24 hours a day, seven days a week, either in the HMO's own facilities or through arrangements with other providers. You must approve these arrangements;

B. **Address Need for Services from Non-HMO Provider.**--The contract must specify the circumstances under which the emergency services are covered when furnished by a provider with which the HMO does not have arrangements, including at least the following situation:

- o The services were needed immediately because of an injury or sudden illness; and
- o The time required to reach the HMO's facilities, or the facilities with which the contractor has arrangements, would have meant risk of permanent damage to the recipient's health; and

C. Address Payment for Emergency Services Delivered by Non-HMO Providers.--The contract must specify whether it is the HMO or you who pays for covered emergency services that are furnished by providers with which the HMO does not have arrangements.

2091.6 Grievance Procedure.--As stated in 42 CFR 434.32, the contract must provide for an internal (to the HMO) grievance procedure that:

A. Provides Resolution.--The grievance procedure must provide for prompt resolution of grievances;

B. Requires Corrective Action.--The grievance procedure must assure the participation of individuals with the authority to require corrective action; and

C. Has State Medicaid Agency Written Approval.--The grievance procedure must be approved in writing by you.

2091.7 Internal Quality Assurance System.--As stated in 42 CFR 434.34, the contract must require the HMO to have an internal quality assurance system that:

- o Is consistent with the utilization control program required by HCFA for your State's overall Medicaid program, as described in 42 CFR 456;

- o Provides for review by appropriate health professionals of the process followed in providing health services;

- o Provides for systematic data collection of performance and patient results;

- o Provides for interpretation of this data to the practitioners; and

- o Provides for making needed changes.

2091.8 External Independent Quality Review of HMO.--You are required to have one of three types of entities (which must not be an entity of the State government) conduct on an annual basis an independent, external review of the quality of services furnished by each HMO under contract to you. The results of the review must be made available to you and, upon request, to the Secretary, the Inspector General, and the Comptroller General. (See §1902(a)(30)(C) of the Act.) The types of entities which are allowed to perform this function are:

A. PROs.--These are utilization and quality control peer review organizations that are under contract to HCFA to perform utilization and quality review for the Medicare program.

B. An Entity that is Eligible to be a PRO.--These are entities which do not currently have a contract with HCFA to perform the Medicare review mentioned but which the Secretary has determined to have satisfied the requirements of §1152 of the Act.

C. A Private Accreditation Body.--Eligibility of an entity to qualify as a private accreditation body to perform this function is determined by HCFA on case by case basis. Generally, in order to qualify, an entity must be a private entity that performs an ongoing accrediting function that is

substantially similar in nature to the role it would perform under §1902(a)(30)(C) of the Act. If you believe that an entity with which you wish to contract is a private accreditation body within the meaning of §1902(a)(30)(C) of the Act, have your RO forward a request for it to be so designated with supporting justification to the CO.

2092. ADDITIONAL STATE AGENCY RESPONSIBILITIES

2092.1 Periodic Medical Audits.--You must establish a system of periodic medical audits to insure that each contractor furnishes quality and accessible health care to Medicaid recipients. (See 42 CFR 434.53.) The audits must:

- o Be conducted at least once a year for each HMO;
- o Identify and collect management data for use by medical audit personnel; and
- o Provide that the data includes information on use of services and reasons for enrollment and termination.

This requirement is in addition to the requirement that you contract with an entity which is not part of the State government to perform an annual independent, external review of the quality of services delivered under each contract with an HMO, as discussed in §2091.2.

2092.2 Continued Service to Recipients Whose Enrollment is Terminated.--You must ensure that Medicaid services continue without delay for any recipient whose HMO enrollment is terminated (unless terminated due to Medicaid ineligibility).

2092.3 Monitoring Activities.--You must have procedures in place to monitor enrollment and termination practices and ensure proper implementation of the contractor's grievance procedures. (See 42 CFR 434.63.)

2092.4 Sanctions.--Section 1903(m)(5)(B)(ii) of the Act vests the Secretary with the authority to deny Medicaid payments to an HMO for enrollees who enroll after the date on which the HMO has been found to have committed one of the violations set forth in this section.

While the statute provides for a denial of FFP, your contracts specify that State payments for new enrollees of the contracting organization are automatically denied whenever, and for so long as, Federal payment for such enrollees has been denied as a result of the commission of such violations.

The following violations can trigger denial of payment pursuant to §1903(m)(5) of the Act:

- o Substantial failure to provide required medically necessary items and services when the failure has adversely affected (or has substantial likelihood of adversely affecting) an enrollee;
- o Imposition of premiums on Medicaid enrollees in excess of permitted premiums;
- o Discrimination among Medicaid recipients with respect to enrollment, reenrollment, or disenrollment on the basis of their health status or requirements for health care services; or
- o Misrepresentation or falsification of certain information.

Monitor HMOs for such violations and bring any cases in which you believe such violations may have occurred to HCFA's attention immediately.

2092.5 Proof of HMO Capability.--You must obtain from each HMO proof of:

- o Financial responsibility, including proof of adequate protection against insolvency; and
- o The HMO's ability to provide the services under the contract efficiently, effectively, and economically. (See 42 CFR 434.50.)

2092.6 HMO's Furnishing of Required Services.--You must obtain assurances that each HMO furnishes the health services required by enrolled recipients as promptly as is appropriate and that each HMO's services meet your quality standards. (See 42 CFR 434.52.)

2092.7 Limit on Payment to Other Providers.--You must ensure that, except in cases of emergency, no payment is made for services furnished by a provider other than the contractor if the services were available under the contract. (See 42 CFR 434.57.)

2092.8 Computation of Capitation Fees.--You must determine that the capitation fees and any other payments provided for in the contract are computed on an actuarially sound basis. (See 42 CFR 434.61.)

2092.9 Services Included in the State Plan but Not Covered Under the Contract.--If the contract does not cover all services available under the State Plan, you must arrange for services not included to be available and accessible. This may be done by having the HMO refer enrolled recipients to other providers or by some other means. (See 42 CFR 434.65.)